POPE JOHN PAUL II
Regional Catholic Elementary School
GROWING IN FAITH, LEARNING FOR TOMORROW

Pope John Paul II Regional Catholic Elementary School

ADDITIONAL INFORMATION

A #

CHILD'S INFORMATION (PLEASE PRINT)

LAST NAME:		FIRST NAME:	MIDDLE NAME:		GRADE ENTERING:	SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	GENDER M___ F___	ETHNICITY WHITE ___ BLACK ___ ASIAN ___ MULTI RACIAL ___		HISPANIC Y___ N___	BIRTH COUNTRY:		LANGUAGE SPOKEN AT HOME:

HOME SITUATION (CHECK ALL THAT APPLY)

___ TWO BIOLOGICAL PARENTS ___ MARRIED ___ MOTHER/STEPFATHER ___ FATHER/STEPMOTHER ___ ONE PARENT ___ SEPARATED ___ DIVORCED ___ LEGAL GUARDIAN(S)	**PARENTAL RIGHTS:** In case of seperation or divorce please complete **LEGAL CUSTODY:** __ Joint Custody __ Sole Custody __ Mother __ Father **PHYSICAL CUSTODY:** __ Joint Custody __ Sole Custody __ Mother __ Father	**LEGAL GUARDIAN(S):** ________________ **RELATIONSHIP TO STUDENT:** ________________

PLEASE NOTE: IN CASE OF SEPERATION, DIVORCE, OR LEGAL CUSTODY THE PRINCIPAL MUST HAVE A COPY OF THE AGREEMENT OR COURT ORDER OUTLINING LEGAL AND PHYSICAL CUSTODY - Please send to Sister Anne McGuire, IHM, Principal

2875 Manor Road
West Brandywine, Pennsylvania 19320

Phone#610-384-5961
Fax#610-384-5730

www.popejohnpaul2sch.org

PLEASE SIGN BELOW:

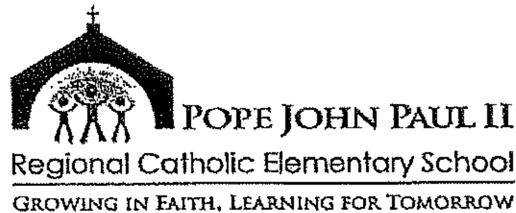
All Parents or Guardians of children are required to sign the following form once, while your child/children are enrolled in Pope John Paul II Regional Elementary School.

I hereby request of the Secretary of Education of Pennsylvania the loan of Instructional materials and textbooks in accordance with Act 90 (1975), Act 195 (1972), and Act 88 (1975) for my child/children attending Pope John Paul II Regional Elementary in Coatesville, Chester County, Pennsylvania.

Signed: ______________________________
Parent/ Guardian

____
Please also print your name

DATE: ______________



PARENTAL CONTRACT

Dear Parent(s) or Guardian:

The following is the policy for Pope John Paul II Regional Catholic Elementary School for all monies due, i.e. Tuition, After School Program, etc...,:

1. All Tuition must be paid in full by April 15th of the school year. Tuition is paid directly to SMART.
2. All After School Program (CARES) money must be paid by the due date on the monthly billing.
3. If any payments are not up-to-date on a monthly basis, your child/children will not be able to participate in the following:
    a. class trips
    b. receipt of report cards
    c. Kindergarten and Eighth Grade Graduations

I will abide by the above policy in regard to all payments for each school year that my child/children attend Pope John Paul II Regional Catholic Elementary School.

______________________________ ____________________

Parent(s) Guardian Signature **Date**

SMART TUITION
Financial Solutions for Schools and Parents

Pope John Paul II Regional Catholic ES - 10164
2875 MANOR ROAD
WEST BRANDYWINE, PA 19320

1 0 1 6 4 1 6 1 8 0 8

2016-2017

PLEASE ENTER FAMILY INFORMATION

FIRST NAME OF PARENT/GUARDIAN/BILL PAYER
LAST NAME OF PARENT/GUARDIAN/BILL PAYER
*FIRST NAME OF ADDITIONAL AUTHORIZED PARTY
*LAST NAME OF ADDITIONAL AUTHORIZED PARTY
STREET ADDRESS OR P.O. BOX
APT#
CITY
STATE
ZIP CODE
HOME TELEPHONE NUMBER
MOBILE TELEPHONE NUMBER
EMAIL ADDRESS (Smart emails reminders for upcoming payments)

SELECT A PAYMENT METHOD

☐ I agree to make payments by mail, web or telephone. I agree to the following due date: **1 5**

Your school allows the following due date:
15

☐ I authorize SMART to automatically debit my payments from the below provided account. I agree to the following automatic payment date:

Your school allows the following due dates (choose one):
15,25

PLEASE DEBIT MY: ☐ CHECKING (PLEASE ATTACH A VOIDED CHECK) OR ☐ SAVINGS

9 DIGIT ROUTING NUMBER
BANK ACCOUNT NUMBER

PLEASE CHARGE MY: ☐ AMEX ☐ DISCOVER ☐ MASTERCARD ☐ VISA

CREDIT CARD NUMBER
EXPIRATION DATE /

A 2.65% convenience fee applies to all credit/debit card payments.

SELECT A PAYMENT PLAN

Plan	Payments	Months
Plan N	12 Payments	May - Apr
Plan Q	4 Payments	Jun, Sep, Dec, Mar
Plan S	2 Payments	Jun, Dec

ENTER PLAN LETTER HERE

ENTER STUDENT INFORMATION

Choose from the following grades: PK 3, PK 4, K, 1 - 8

GRADE
FIRST NAME OF STUDENT
LAST NAME OF STUDENT

FOR SCHOOL OFFICE USE ONLY

☐ THIS FAMILY IS ENROLLING LATE:
☐ SPREAD BALANCE ACROSS REMAINING MONTHS OF PLAN
☐ COLLECT BALANCE IN FIRST MONTH

*OPTIONAL STUDENT ID

STUDENT TUITION 1 $
STUDENT TUITION 2 $
STUDENT TUITION 3 $
STUDENT TUITION 4 $

FAMILY TUITION SUBTOTAL $

*OPTIONAL SCHOOL FAMILY ID:
*OPTIONAL TYPE CODE:

PLEASE READ AND SIGN

I have read and agree to the terms and conditions on the reverse side of this document. I agree that the school may re-enroll me in the Smart Tuition payment program for each subsequent school year. I agree to pay the amount established by my school for the student(s) above by my specified due date. I realize that if I fail to have a payment posted or if there is an outstanding balance on my account by the specified due date, such action will result in a school late fee of $20.00. A $30.00 fee will apply for any failed electronic transaction or dishonored check.

PRIMARY BILL PAYER ____________________ DATE ___/___/___

FEES & DISCOUNTS

If fees and discounts should be applied in addition to the tuition amounts included above, please contact your account manager.

ANNUAL TOTAL DUE $

Pope John Paul II Regional Catholic Elementary School

MEDICAL INFORMATION

M

CHILD'S LAST NAME:	FIRST NAME:	MIDDLE NAME:

MEDICAL INFORMATION

Does your child have any chronic illness that we should be aware of (i.e. Asthma, Allergies)? If Yes please explain below

____

____

Does your child wear glasses or contact lenses? YES ____ NO _____

CERTIFICATE OF IMMUNIZATION

The Pennsylvania School Health Law states:

The following minimum Immunizations are requires for all students entering school for the first time or into Kindergarten.

- 4 doses - Tetanus (1 dose after the 4th birthday)
- 4 doses - Diphtheria (1 dose after the 4th birthday)
- 3 doses - Polio
- 2 doses - Measles
- 2 doses - Mumps
- 1 dose - Rubella (German Measles)
- 3 doses - Hepatitis B
- 2 doses - Varicella vaccine (chickenpox) or history of the disease

CHILDREN ENTERING 7TH GRADE

- 1 dose - Meningococcal Conjugate vaccine (MCV)
- 1 dose - Tetanus
- 1 dose - Diptheria
- 1 dose - Accellular Pertussis (Tdap)
- If 5 years has elapsed since last Tetanus immunization

In accordance with the State Regulations a child will not be admitted to scholl until his/her certificate of immunization or exemption* is completed by a physician or other health care provider.

** The following is the position of the Church around the issue of immunization:*

The Pontifical Academy for Life encourages Catholics to use alternate vaccines when they are available. Unfortunately, none exist at this time. For this reason, Catholics may use these vaccines with a clear conscience.

The Pontifical Academy also strongly encourages parents to vaccinate their children for the common good, since contact with a virus may cause serious harm to otherws, particularly in the case of a pregnant mother contracting the rubella virus.

For these reasons, the Church does not consider parents' objections as grounds for a "religious exemption" from vaccination

A PHYSICAL EXAM is required for: -
- All students entering school for the first time
- All Sixth Graders are required to have a new physical
- All Students coming from out of State

A PHYSICAL EXAM is required for: -
- All students entering school for the first time
- Third and Seventh Graders are required to have a new dental exam

COATESVILLE AREA SCHOOL DISTRICT

COATESVILLE, PENNSYLVANIA

HEALTH HISTORY PERMISSION FORM (INITIAL HISTORY)

STUDENT NAME:______________________________________

THE NATURE OF THE HEALTH HISTORY

I understand that the information I give to the School Nurse is important for the school staff to understand and help the health and education of my child.

I understand that the information will be kept confidential by the School Health Staff, and will be shared with other professionals in the school and in other institutions only when the School Nurse/Nurse Practitioner/School Physician believes that it is in the best interest of the child's health and education.

Copies of this health history will be sent to other agencies who request it only with my written permission.

____________ ____________________________________

Date Signature of Parent/Guardian

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ______________________ Today's date____________

Date of birth ____________ Age at time of exam________ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student…*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student…*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student…*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student…*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student…*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: ________		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ____________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student…*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other________		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other________		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS or CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student________________________ Date__________

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

*MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam ____________ 20____

Print name of examiner ______________________________

Print examiner's office address ______________________________ Phone ______________

Signature of examiner ______________________________ MD ☐ DO ☐ PAC ☐ CRNP ☐

HEALTH CARE PROVIDERS: *Please photocopy immunization history from student's record – OR – insert information below*

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:________ Reason: ________________________ Date Rescinded:________

Medical ☐ Date Issued:________ Reason: ________________________ Date Rescinded:________

Medical ☐ Date Issued:________ Reason: ________________________ Date Rescinded:________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine, (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)